



Exploring the Roots *of* Health Inequity

Essays for Reflection

NACCHO
National Association of County & City Health Officials

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Introduction

A vast and growing literature on health inequity and social justice has been available for some time. The importance of this work becomes more urgent with the extensive increase in inequality in the United States. However, this literature—specifically emphasizing root causes—has not been aimed at public health practitioners. These practitioners encounter systematic health inequities in their daily work.

The National Association of County and City Health Officials (NACCHO) has produced four brief essays designed to explore conceptual themes associated with health inequity, especially root causes. The intention is to generate dialogue among public health practitioners concerned about the growing health inequities. They already recognize that these inequities are not an unfortunate outcome of circumstance or bad behavior, but a result of ongoing social injustice.

NACCHO's purpose is to inspire reflection about how practice might emphasize strategies directed toward preventing inequity, rather than primarily treating its outcomes, by focusing on the institutions and forces that drive it. The essays are neither comprehensive nor a summary of literature nor a practical guide; no simple translation exists between the ideas presented to immediate practice or models of practice. Instead, we seek to offer insight and challenge conventional narratives in a way that may suggest different paths for practice. The themes are meant to induce rethinking features and processes of public health practice. We hope that they inspire the reader to ask critical questions and reimagine possibilities.

One overall assumption in the essay series is that success in confronting the root causes of health inequity requires expanding the boundaries of public health practice beyond a bio-medical paradigm and building permanent alliances with the constituencies served. Another assumption is that values need to be made salient in the conduct of public health work. NACCHO believes the work force in public health would enhance its effectiveness by integrating with or relying on a knowledge base within sociology and philosophy and political economy (which have a rich literature connected to social justice and equality) and questioning orthodoxy about the rules of legitimate practice.

With a short description about health inequity, intended to set the stage, the essays include four topics or themes: (1) social justice, which explores the meaning and relevance of this concept as a framework for guiding public health practice and examines its central principles; (2) public health history and reform, which examines some core features since the mid-nineteenth century, and the political and ideological forces shaping its scope and boundaries; (3) racism and class structure, which is divided into two parts: the first part examines selected aspects of structural racism, the legacy of racial oppression, and its connection to poor health outcomes, and the second part examines class structure and how it clarifies the connection and importance of viewing class as a social relation of power generating differential class positions and the resulting inequitable health outcomes; and (4) knowledge: frameworks and development, which considers the relevance of frameworks, concepts, and questions for investigating health inequity, and the need for public health to work with its constituencies in the pursuit of an effective knowledge base.

These few essays are a starting point for an expanded conversation on each of the themes and concepts. Additional essays may be produced in the future as we learn from the field of practice. NACCHO is seeking to engage health practitioners with the subject matter in a way that shifts thinking about what practice would have to look like to be effective at confronting the drivers embedded in society's structures that create health inequities.

Health Inequity | A Brief Overview

What Is Health Inequity?

British philosopher and economist Amartya Sen suggests that health equity is realized when every person has the opportunity to achieve their full capabilities and potential for health and well-being.¹ According to British analyst Margaret Whitehead, health inequities refer to differences in the distribution of disease and illness that are systemic, patterned, unjust, unnecessary, and actionable.² They are not the result of unfortunate, random events or differences caused by individual behavior or genetics.

Some Examples of Health Inequity

Differences in health can be found among socially, economically, and geographically defined population groups. For example, rates of disease and illness across all categories are increasing for people with low income and in most geographic areas in the United States. Those population groups living in poverty in the United States have eight times the level of coronary heart disease compared with higher income groups and levels of wealth.³ Twenty-one percent of children live in poverty and have significantly poorer health outcomes than those not living in poverty. Blacks have at least 2.5 times the infant mortality rate of Whites in many jurisdictions.⁴ Immigrants tend to have their health worsen the longer they live in the United States.⁵ Native American populations, “on or near reservations...had some of the worst mortality outcomes in the country.”⁶ These outcomes are inequitable because they demonstrate repeated and systematic patterns that cannot be explained by behavior or genetics.

The Connection Between Social and Economic Inequality and Health Inequity

Health inequities are increasing in tandem with and produced by rising social and economic inequality. The most equitable societies in the world with the least amount of social and economic inequality have the best health status.⁷ They are also the ones that place more resources on the foundations for health, by setting the prerequisite conditions. Despite its great wealth, by many measures the United States is one of the most inequitable countries in the world. Levels of economic inequality are the highest

they have been at any time since before the Great Depression.⁸ Unsurprisingly, the United States has the worst health in the industrialized world. More than 30 countries have better health than the United States.⁹ These vast inequitable differences in wealth and power means that groups of people are born into, live, work, and grow old under vastly different economic and social conditions. “Inequalities in health are thus closely tied to inequalities in the most basic freedoms and opportunities that people can enjoy.”¹⁰

Consequences

Health inequities pose serious consequences and great social costs, particularly by limiting the ability of some population groups to gain access to needed resources and express their political and cultural voice. Such groups are less likely to achieve their full human capabilities, and participate effectively in community social and political life. More generally, the lack of access to decision-making structures and the ability to participate in everyday life, leads to worse health. As sociologist Goran Therborn reminds us, “Inequality is a violation of human dignity; it is a denial of the possibility for everybody’s human capabilities to develop....It takes many forms and it has many effects: premature death, ill-health...poverty, powerlessness, insecurity...and exclusion from opportunities and life chances.”¹¹ And Economist Sudhir Anand further notes, “Health [is] a special good, which has both intrinsic and instrumental value....Health is regarded as being critical because it directly affects a person’s well-being and is a prerequisite to her functioning as an agent.”¹²

Causes and Politics

Confusion often exists, in discussing causality, between an emphasis on social determinants of health, such as housing, education, and transportation, for example, versus social relations and power arrangements (the social determinants or determinations of health inequity) that create the unequal life conditions over which people have little or no control.¹³ Poor quality of housing and a degraded living environment may create negative health outcomes; however, it is the systems of regularly produced patterns of interconnected institutional decisions, rules, and processes over time for which there is little or no public accountability that actually creates inequitable health outcomes. Health is therefore political because some have more of it than others for reasons not of their own making.¹⁴ As Fabienne Peter contends, “the pursuit of health equity [is viewed as] embedded in and interlinked with the pursuit of social justice....The emphasis thus lies not on the pattern of distribution of health outcomes but on the broader social processes underlying health inequalities.”¹⁵ Concepts associated with those underlying health inequalities are the subject of the following four essays.

Notes

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7. Richard Wilkinson and Kate Pickett, *The Spirit Level: Why Equality Is Better for Everyone* (New York: Penguin, 2010); see also Stephen Bezruchka, "Inequality Kills," in *Divided: The Perils of Our Growing Inequality*, David Cay Johnston, ed. (New York: New Press, 2014).
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9. Steven H. Woolf and Lauden Aron, eds., "U.S. in International Perspective: Shorter Lives, Poorer Health," Panel on Understanding Cross National Health Differences among High Income Countries, Committee on Population, Division of Behavioral Sciences and Health and Education, National Research Council and Institute of Medicine (Washington, DC: National Academies Press, 2014); Bezruchka, Note 6.
10. Sudhir Anand, "The Concern for Equity in Health," in *Health, Ethics and Equity*, Sudhir Anand et al., eds. (Oxford University Press, 2004), 16; see also Dennis Raphael, "Introduction to the Social Determinants of Health," in *Social Determinants of Health: Canadian Perspectives*, Dennis Raphael, ed. (Toronto: Scholars Press, 2004).
11. Goran Therborn, *The Killing Fields of Inequality* (Cambridge, MA: Polity Press, 2013), 1.
12. Anand, "The Concern for Equity in Health," note 10.

13. See Anne-Emanuelle Birn, “Making It Politic(al): Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,” *Social Medicine* 4, no. 3 (September 2009): 168–82.
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Essay 1 | Social Justice: The Foundation of Public Health

“Social injustice is killing people on a grand scale.”¹

In the opening lines of its 2008 report, the World Health Organization’s Commission on Social Determinants of Health states: “Social Justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death.” One of the Commission’s three key recommendations states: “Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.”²

This essay explores the relevance and meaning of social justice as a framework for guiding the work of public health, with particular emphasis on its relation to the root causes of health inequity. It examines four central principles of social justice and considers some implications for public health practice.

Introduction: Why Social Justice Matters to the Health of a Society

At its core, a socially just society is one where people can exercise their capabilities, living fully, and sustaining a flourishing human existence, in a safe and healthy environment.³ Such a society seeks to equalize the economic, social, and political system to create the circumstances that produce life-supporting conditions. It is one in which groups of people have the power to participate in decisions that affect their living and working conditions on an equitable basis. Thus it is important to democracy.

If (1) social injustice is “killing people,” (2) the field of public health strives to alleviate suffering and improve the quality of life for entire populations and (3) ensure the conditions in which people can be healthy,⁴ then public health must concern itself with social justice because that work transcends attention only to biological functioning. Health equity is an objective as part of the larger goal of social justice because inequity in health status is deeply related to the pervasive effects of power arrangements, privileges,

and hierarchies. Public health and social justice both derive from society's obligation to the common good, as well as the recognition that health is a cornerstone of a functional society and fundamental to the pursuit of happiness. Social injustice thwarts public health's mission.

Access to things like good housing conditions, quality schools, transportation, and neighborhood safety affect people's abilities to live well and participate fully in society. Health departments have begun to promote strategies to assure these conditions. However, why is it that some groups in society do not experience the conditions that create health or the political power to influence them? What generates outcomes that harm health in the first place? The patterns researchers find in inequalities in life expectancy and infant mortality, for example, are neither accidental nor natural, nor are they related primarily to lifestyles, psychological characteristics, or random events.⁵

What Is Social Justice?

Many philosophers, theologians, and legal scholars since Socrates have discussed social justice under different names and developed different conceptions of its meaning and purpose. The term itself was first used by a Catholic priest in 1840, based on the writings of St. Thomas Aquinas and later interpreted through Liberation Theology.^{6,7} In the United States, social movements from the abolitionists and the labor movement to civil rights and the women's movement have been responsible for major advances in the public's health.⁸ In this view, social justice concerns the realization of well-being, meeting fundamental human needs through social cooperation, and minimizing institutional forms that enable some groups to control and benefit from the capacities of others. Social justice expressed as a characteristic of societies and their institutions, not a property of individuals, is about a prerequisite for healthy human development.⁹ Indeed, the healthiest nations are the most socially just.¹⁰

Social justice can be defined by at least four related health promoting principles: (1) social and economic equality, which refers to creating a structure of equality in society's basic institutions; (2) political equality, which includes the ability to participate fully in a democracy, and to avoid a disproportionate advantage or disadvantage in influencing public decisions; (3) freedom, which has many meanings, here refers both to the capacity to achieve health and well-being, and control over choices to ensure well-being;¹¹ and (4) autonomy, or the ability of groups or classes of people to maintain control over their identities and culture, and their labor and the conditions of labor.

These principles can themselves be justified not because people are the same but because of their humanity, because they think, feel, and have needs and capacities. Their realization has typically required connections to social movements.

Social and Economic Equality

Social and economic equality concern society's equitable treatment of groups of people. Societies realize this when they act in ways that enable people to meet their basic material needs, fully express their capabilities and identities, and enable their culture to flourish. In such societies there would likely be somewhat less need for the type and scope of compensatory programs or policies because such societies are less likely to create conditions that lead to their necessity in the first place.

Consider, for example, why two physically proximate neighborhoods would have vastly different life expectancies and mortality rates. Typically if one lacks access to basic transportation services, experiences high levels of displacement through gentrification, has minimal access to well-paying jobs, lacks affordable and safe housing, has significantly less investment in or resources devoted to city infrastructure (sewage treatment, quality schools, sanitation), we find poor health outcomes. These are not random or coincidental; they arise from imbalances in political power. Fabienne Peter explains further what makes health inequity unjust:

“...social inequalities in health are wrong not simply because actual health outcomes deviate from some pattern of health outcomes that is considered ideal, but because, and insofar as, they are the expression and product of unjust economic, social, and political institutions. It thus embeds the pursuit of health equity in the pursuit of social justice in general.”¹²

When people experience social and economic inequality, it influences their social position, which is linked to mortality rates by way of various health issues, including infectious diseases; mental disorders; violence; and diseases of the circulatory, respiratory, nervous, digestive, and musculoskeletal systems.¹³ In the United States, a country that ranks low on social equity indicators, some groups of people experience vast differences in life expectancy. Based on income, the top 5 percent of Americans live about nine years longer than the bottom 10 percent.¹⁴ Social injustices establish the differential exposure to risk and vulnerability. Inequalities reinforce each other, creating a cascade of disadvantages, which can be reproduced through generations.

Residents in communities with higher rates of crime, poor quality schools, longer firefighting response times, decreased access to nutritious foods, and multiple stressors, for example, will have higher blood pressure and other chronic conditions. Populations excluded from access to resources, shelter, a stable ecosystem, and full participation in mainstream social life experience worse health outcomes than do populations that are not excluded. The conditions of social existence are the primary determinants of inequalities in health status.

Political Equality and Democracy

Political equality, or democracy, a second dimension of social justice, concerns the means and ability people have to participate effectively in society's institutions—that is, fully express their interests and concerns through accountable and transparent institutions, in order to have control over the policies and practices that influence everything from their educational opportunities to their ability to get a job or a home loan. Social and economic equality are not possible without political equality because the former requires constraints on power.¹⁵

Political equality generally refers to democratic governance, which means decision-making systems that are participatory, interactive, inclusive, representative, transparent, and publicly accountable. They allow for public and open, fair, and deliberative processes. Achieving political equality requires an expanded set of venues, forums, and locations for participation. Iris Marion Young argues that the structures of communication and cooperation matter and stresses the need for “making the collective regulations [of institutional relations] designed to prevent domination [in these structures.]”¹⁶ The public's health is closely tied to, if not dependent on, political equality or democracy. It is a prerequisite for health equity.

An example of political equality would be the increase in political power that occurred for African Americans and people of color more generally during the Civil Rights movement, or the labor movement's gaining the right to collective bargaining.

An example of political inequality would be those situations where unequal power expands the ability of some interests to do things such as plan development projects without informing or involving citizens. This often occurs in determining the location of polluting sites or in redevelopment projects that will result in displacing thousands of people. Another example involves efforts of institutions to limit legitimate claims that can be made in the courts, such as class actions or even the right to bring lawsuits.

Democracy depends on a strong public sphere and the willingness of people to participate in social movements aimed at the collective empowerment of *whole classes of people*. It also depends on support for the social relations and political arrangements necessary to sustain and expand that power. More than formal processes, such as voting, it is defined through cooperation, in relation to participation in all institutions, public and private, that direct society and shape people's lives. These institutions include the family, schools, and businesses, and greater popular control over basic social decisions that determine what gets produced and distributed and for whom. Democracy's roots in this regard derive from principles of inclusion rather than exclusion. According to the World Health Organization Commission on the Social Determinants of Health, governments have a

responsibility to extend decision-making power to groups that have been marginalized and experienced the greatest level of health inequities.¹⁷

Research shows that those who have more control over their work and social life have healthier, longer, and more productive lives.¹⁸ The increasing pace of work and demands for higher productivity stress the immune system. When groups of people lose their homes because of unaccountable decisions by real estate developers or banks, the trauma and the lack of control creates health issues.

The United States' power structure institutionalizes and normalizes inequality—a key determinant of health inequity—and is a threat to the health and well-being of entire populations.¹⁹ Political inequality remains a fixture of U.S. society and plays a major role in sustaining the current and increasing level of social and economic inequality.²⁰

Freedom and Liberation

Freedom is another key principle of social justice with many meanings. It refers here both to capabilities providing the ability to make choices to achieve well-being and the ability of all social groups in society to express their identity, values, language, and culture in a positive way. The latter concerns groups of people having their cultural difference affirmed and choosing to live in any community without restriction. In addition, it refers to the ability to access public resources and to be free from want. Freedom takes many forms, including freedom from having to conform to the dominant culture to the affirmation of group differences. But freedom as having capacity, to be able to act, to do things, and to function effectively implies processes that enable it.²¹

Threats to that freedom can come from direct oppression, such as slavery or segregation; from violence, including both individual attacks against people and their property, and more systemic assaults, such as in degrading depictions of women in the media; from cultural imperialism, in which dominant groups project their own experience as representative of everyone, as the U.S. government did when it restricted American Indians' freedom to speak their own language; or from various laws and practices, which allow some groups to withhold resources from or otherwise dominate, exploit, marginalize, or exclude others from meaningful participation in society.²²

Subtle efforts to inhibit people's ability to enjoy freedom are woven throughout the daily practices of government and business. For instance, consider the ways that those in the lesbian, gay, bisexual, transgender, and queer communities routinely experience employment discrimination and harassment, or the pressures on Muslims seeking to practice their religion without fear of persecution. Each of these things can threaten health in large part by saddling oppressed groups with stress.

Autonomy (Group Self-Determination)

The final core principle of social justice is autonomy. Autonomy refers to groups in society (defined by class, race, gender, sexual orientation) having the authority to make decisions about their lives by having a voice and the power to develop their capacities without systematic constraints. It means having control over the conditions in their social, work, and political lives. This would include, for example, opposition to patriarchy (the social authority of men) or constraints on the ability to engage fully in political life (self-government of a people) without coercion, manipulation, or other obstacles. The latter would include the ability to establish conditions of work and organize to act to meet basic life needs, as noted under the first principle.

Autonomy, while related to democracy through a role in decision making that determines a group's governance, is more about their power. In addition, to be autonomous, people require access to public resources, such as public education, libraries, transportation, and other infrastructure, making them capable of deliberating collectively and freely with others.²³ On another level, autonomy is the ability for groups of people to resist subjugation to oppressive institutions, as members of a particular group, such as workers or women of color, or lesbians and gays. They would experience self-determination, personal security, and respect—both from others and from themselves. Yet when the other principles of social justice are compromised—when people have little income or wealth, experience poor living conditions, or are unable to participate in democracy—autonomy is not possible.

A lack of autonomy can have serious health consequences. Evidence of this occurs in the workplace, which multiple studies have shown can directly impact health by denying most employees, as a group, control over their work.²⁴ For example, a study of female workers in the United States showed that women with a heavy workload and little control over their work faced a risk for coronary heart disease three times greater than that of women with the same workload but more control over their jobs.²⁵

The realization of each principle is not about just distribution of resources but instead concerns the structure of interlocking institutions and the power they exercise over practices and procedures that govern our lives.²⁶ These principles offer an explanation for why social justice should be accepted as the foundation of public health: to meet basic human needs for life and well-being and living fully, and to support establishing conditions that do not disproportionately expose some populations to health hazards, risks, and vulnerabilities.

Implications for Health Departments

Embracing a framework based on these principles of social justice can help public health practitioners strategize to reverse unbalanced power dynamics and create the conditions that support health. Its principles enable imagining a different kind of society. Social justice movements can transcend single issue campaigns by aiming for broader social change. The end of child labor, the introduction of housing codes, the right of women to vote, the Civil Rights movement, the eight-hour work day, and marriage equality for lesbians and gays are all examples of struggles for social justice—ones that have resulted in advances in life expectancy and reductions in mortality rates.

Although striving for social justice is difficult and requires long-term commitment and struggle,²⁷ the effort is critical because social justice is the foundation of public health.²⁸ It is a prerequisite for human development²⁹ and the basis for meeting basic human needs.³⁰ The healthiest nations tend to be those that are the more socially just. They typically have high levels of democracy and low levels of inequality. In Finland, for example, where income inequality is low, social trust, the status of women, and life expectancy all are higher than they are in the United States, where income inequality is high.³¹ In other words, everyone gains in a more socially just society.

Working with limited resources, public health practitioners can strive to reduce rates of morbidity and mortality. Supporting communities in achieving good housing conditions, quality schools, and neighborhood safety will affect people's capacity to live well and participate fully in society. Health departments are increasingly promoting strategies to address assuring these conditions.

Considering the scope of work involved in changing the social structure and its most deeply embedded ideologies is overwhelming. It's easy to become paralyzed by the concern that social forces beyond immediate control are shaping people's health, and it can be difficult to imagine how public health can change that trajectory. What may be useful for public health practitioners and their community partners, then, is to imagine that this structure has already changed. How would the country be different? How would that affect the way health departments function? How might they conduct the work of public health based on principles of social justice, even if in small ways?

The country's health would rest on a solid foundation whereby everyone living in the United States would enjoy social and economic equality and be fully included in democratic processes. All community members would be able to participate or effectively represented in all decision-making processes that shape the conditions and control the resources needed to lead thriving and healthy lives. Free from oppression, they would experience a sense of solidarity, and the ability to have greater control over their work lives. Each of these developments would enable people to be healthy and live well. Such

a foundation would be a reflection of commitment to a shared responsibility between individuals and institutions to protect and improve the public's health.

This kind of social transformation is, of course, a long time in the making. Health departments have budgets and deadlines and communities with urgent health needs. But health departments can still play an active role in helping to develop the popular support needed to address the root causes of health inequity while also meeting urgent health needs.³²

Principles of social justice can guide daily work and support strategic planning about where, how, and when to take action beyond conventional programmatic functions. For example, by recognizing how political equality is being jeopardized, the role they might play can align with their constituency in determining how decision making can be made more democratic. Such change can be very difficult. The challenge is to generate the small transitional changes that collectively lead to structural transformation over the long term, rather than endlessly remediating the consequences of social injustice. For example, seeking to prevent displacement of populations due to land use decisions or housing policy may more permanently and effectively strengthen community health rather than programs and services subsequent to the trauma caused. The actions required must match the scale of the injustice.

Interpreting information from a social justice perspective can lead to changes in strategy. On the one hand, identifying high rates of respiratory illness in a low-income community may conventionally suggest relying on an educational approach resulting in behavior modification. On the other hand, a social justice lens would indicate the need to explore the pattern of decisions and power relations that may be producing the environmental conditions that lead to respiratory illness. This analysis could begin with identifying the distribution of polluting sites across neighborhoods, in order to determine if the lhd could do more to prevent decisions that repeatedly place some neighborhoods at greater risk for environmental hazards.

Reversing social injustices requires more than policy changes associated with a redistribution of material goods and resources. It requires rethinking and rearranging the structure of society in its power arrangements, because that is where social injustices arise. They take root in longstanding power imbalances.

Conclusion

Social justice is the foundation of a healthy democracy and healthy people. It allows all people to participate fully in the co-creation of an equitable society. Lacking social justice, people are unable to achieve their full health potential, and inequities in the distribution of disease, illness, violence, and death are inevitable. By bringing a social justice lens to public health practice, communities can begin to organize to transform the country's social structure toward furthering health equity.

Notes

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Essay 2 | Public Health History and Social Reform

The public's health has taken a winding journey since the nineteenth century seeking to define its purpose but maintained at least one constant since its inception: conflicts over the boundaries and shifting scope of its legitimate work.¹ These struggles have encompassed both the field's ongoing internal challenges (concerning public health's mission, structure, and authority) and external challenges (often with the medical profession and industry). They have involved both adapting to changes in the nature of disease and illness, and evolving views on their causes and ways to maintain and improve population health.

Despite its attempts to remain objective and evidence-based, the field reflects values and interests; public health is not a culture-free enterprise, devoid of context. As public health historian Elizabeth Fee noted, public health history “pervades every aspect of social and cultural life.”² That history is intertwined with how social injustices have structured the life chances of different groups and their opportunity for health and well-being.

Public health has known glowing successes and distressing failures. It has functioned in partnership with communities served and also apart from them. The waxing and waning of public support for and understanding of public health are unsurprising, given the challenges and, often, lack of appropriate resources in the United States.³

Studying the field's history offers insights for shaping future practice—a future now in jeopardy. Health inequities are rising in the United States and are only likely to grow, while widespread layoffs and severe budget cuts at all levels hamper tackling their root causes.⁴ Exploring public health history can inform public health and community leaders about the drivers of health inequities and strategies that might eliminate them. It can serve as a guide for advancing critical thinking about public health practice.⁵

This essay briefly explores selected features of public health's journey from its early days in the nineteenth century, primarily in the United States and Europe, to today in the United States. We examine how it sought to reimagine itself and adapt to meet contemporary

challenges and recapture its once-strong spirit of broad-scale social reform. One question is whether it can leverage that spirit to address more effectively the conditions, structures, and systems that give rise to health inequities. It begins by identifying the origins of modern-day public health. From there, the essay considers the political and ideological forces that have shaped, and continue to shape it, and the possibility for extending its legitimate scope and focus to confront health inequities directly, beyond only treating their consequences. Throughout, the essay reflects on how public health's changing role has led to present-day tensions in the United States about the field's boundaries. Finally, we discuss briefly implications for the future of public health practice.

Advances and Declines in Public Health

Historically, advances in health have come through improving social and economic conditions. Evidence of this dates to 400 B.C.E. with Hippocrates' essay titled "Air, Water and Places,"⁶ which articulated connections between health and non-biological factors. However, widespread documentation of the connection did not begin until the early nineteenth century—the start of the formal practice of modern-day public health.⁷

During that time, the United States and many European countries experienced sudden, violent epidemics of infectious disease. Tuberculosis, the most prevalent, was responsible for almost a third of all deaths in Europe.⁸ Other fear-provoking diseases included the plague, typhus, yellow fever, and cholera.⁹ Cholera spread across the globe five times over during the course of the nineteenth century.¹⁰

These outbreaks happened during a period of urbanization, industrialization, and related upheaval. Industry's demand for cheap labor and the limited political power of the growing immigrant population led to horrendous living and working conditions. Housing became overcrowded, ventilation was poor or nonexistent, and no infrastructure existed for managing water and waste. Children were forced to labor long hours alongside adults; factories spewed contaminants into the air and soil; and rotten food, raw sewage, and decaying animal carcasses lined the streets. As a result, mortality among infants was high, as it was for those who survived into adulthood.¹¹

In industrialized nations today, this Dickensian picture may seem unthinkable. Although enforced to varying degrees, housing codes, worker's rights and laws preventing child labor exist in the United States, Europe, and many other regions. Water pollution remains a problem in some jurisdictions, particularly in American Indian communities and along the U.S.-Mexican border. Although most people in America are able to drink safe water, in some parts of the country many do not have these basic necessities. Such communities do not provide the infrastructure.

The standardization of social and environmental advances by nineteenth century reformers has improved both the length and quality of life for many people. However, we should be cautious about romanticizing past public health reform efforts. This can result in ignoring the limits of public health, the extent of severe social injustices, and the scientific and social context.

This context is crucial to understanding the routes of reform and, ultimately, transformation. Public health, while grounded in science, is fundamentally political because “some social groups have more of it than others...its social determinants are amenable to political interventions...[and] because power is exercised over it as part of a wider economic, social and political system.”¹² The field’s characteristics vary widely from state to state and across communities by county and neighborhood, based on the political power of organized groups, for example, making decisions over things like land use, zoning, transportation, and investments in local infrastructure,¹³ affecting whose needs receive attention, and the way they are framed as a public health issue.¹⁴

Even basic sanitation issues that may now seem matters of common sense were once contested. The nineteenth-century implementation of water and waste management infrastructure involved jurisdictional questions about assigning cost and legal rights.¹⁵ Often, even after such reforms are in place, shifts in power and differences over priorities, for example, economic growth versus health and environmental quality, continue to affect public health’s ability to retain authority for reducing inequities.¹⁶

Early Efforts in Europe

Advances toward improved health and life expectancy have not been straightforward. The nineteenth century was a time of scientific uncertainty, with the circulation of multiple theories about potential causes of disease and the pathways by which they spread.¹⁷ Each gave rise to different attempts at controlling and preventing illness. For example, one theory of disease causality, known as the miasma theory, located both the origin and spread of disease and identified the smell, often from garbage and sewers, as harmful to inhale.¹⁸ This theory, later proven false, formed the basis for many of public health’s early environmentally focused reforms, though obviously not for its scientific accuracy. Rather, the miasma theory advanced because of the political climate, in which people feared diseases associated with poverty.

British lawyer Edwin Chadwick embodied this climate. He became involved in public health, not out of an egalitarian belief that all people had a right to good health, but from a concern for the economic drain on the country from high death rates. Chadwick noted the long-term financial consequences of premature widowhood and orphanhood, which consumed large amounts of aid. His research identified filth as the cause for both poor character and poor health. In his 1842 *Report on the Sanitary Condition of the Labouring*

Population of Great Britain, he drew clear connections between the environment and health. The report recommended sweeping reforms, including removing wastes and foul odors from the city, and developing a single administrative body to handle sewers, drains, water, and roads.¹⁹ It ultimately led to the founding of the General Board of Health, and investments, once privileges of the wealthy, became widely available to people in poverty.²⁰ Far from altruistic, this approach was intended to save money and prevent social unrest.²¹ Had the aim been more progressive in nature, the report might have expanded beyond water and waste to include issues, such as food security or health and safety standards at work.²²

Chadwick's main lesson is that economic motivation cannot itself transform social conditions. The interest was primarily economic—people were resources for the industrial engine. Reducing excess mortality or improving lives devastated by the industrial revolution was a by-product. Yet, public health practitioners today are increasingly driven by a requirement to protect and improve the conditions that influence health. Many do so recognizing that transforming those conditions entails continuing vigilance to the structures and decision processes that sustain the persistence of health inequities.

Early Public Health in the United States

Public health in both Europe and the United States originated with an environmental, sanitarian approach, a necessary response to local threats including epidemic disease, local environmental conditions, and waste management.²³ The United States and Europe also shared common motivations for public health actions, yet widespread concern for the well-being of populations was often absent. Among the ruling classes, a fear of social unrest and even revolution (and the spread of disease) inspired many public health efforts. Public health interests were often at odds with economic and international trade interests.²⁴ When the two conflicted, business interests often won.

When health did surface as a concern, only some groups received attention and resources. For example, in the United States, colonial public health measures were more protective of imperial armies and settlers than indigenous populations. They were driven by profit-focused agendas and agricultural productivity.²⁵ Similarly in Europe, reform efforts provided clean water and sanitation for working-class men important to the economy.²⁶

A continued interest in public health by reform movements did not take hold until late in the nineteenth century, much later than in some European countries.²⁷ Additionally, the United States faced major public health challenges, with mass immigration and industrialization on a scale not seen in Europe. Between 1880 and 1920, about 24 million immigrants entered the United States, encouraged by severe labor shortages,²⁸ quintupling the value of its manufactured goods.²⁹ By 1900, the United States, unlike Europe, lacked a sustainable working-class political movement to organize against widespread social

injustices and environmental degradation from large-scale industrialization. Industry suppressed strikes and fears of social conflict permeated social reform efforts.³⁰

Public Health and the Medical Establishment

The discovery of bacteria as agents of disease³¹ diminished attention to the social causes of ill health. Bacteriology came to represent the “new public health” of scientific professionals,³² and public health reformers and medical professionals developed a controversial, and increasingly adversarial, relationship. Medical professionals discredited public health professionals who still considered social reform as a solution for population health problems,³³ while physicians, who stood to gain prestige with the new scientific breakthrough, feared that reformers would encroach on their turf.³⁴ By 1900 the relationship between the medical and public health communities was severely fractured.³⁵ This fracture set the stage for medicalized public health in the United States, compromised the field’s ability to address the country’s growing health inequities, and hastened its retreat from socially based reform.

In 1916, Herbert Hill, a public health official, wrote a book about the value of what he called the “new public health.” His goal was to reform the individual behaviors of the affected few rather than create sweeping change for the many. This shift, he argued, was cheaper and more efficient than addressing the environmental causes of disease. Disagreements between its advocates and adversaries, continues to characterize public health. Tensions between the two approaches have left the field without a clearly agreed upon mandate.³⁶

By 1916 the progressive movement was also flourishing. Reformers—primarily women members of voluntary health organizations—encouraged a strong governmental role in food safety, education, housing, and the workplace.³⁷ They tried to protect health boards from local politics.³⁸ But these efforts were no match for medicalization, which was well established by the 1920s and further cemented during the following decades.

Public health became more technical and less political, retreating from activism and into clinical and academic settings.³⁹ Public health departments stopped handling sanitation, housing reform, hospital care, and other social reforms⁴⁰ while private practice doctors boasted unearned credit for health achievements.⁴¹

Because people viewed science as external to politics, public health was able to explain disease without engaging racial segregation, inequality, or other social or environmental determinants of health inequity.⁴² Yet, in doing so, the field became more marginalized and less powerful, lacking a political base.⁴³ Public health practitioners’ income fell, making the field less attractive⁴⁴ and ill equipped to confront future problems, such as the shift from infectious to chronic diseases as the leading causes of death. Few professional groups could effectively challenge these changes.⁴⁵

Medicalization formed the backdrop for the field's actions throughout the rest of the century, even as support for public health rose and fell. The 1930s, for example, saw a renewed interest in public health.⁴⁶ New Deal legislation produced Social Security, worker's compensation, disability insurance,⁴⁷ increased funding for state and local health departments, and the creation of several federal agencies dedicated to health.⁴⁸ These influential changes, similar to those earlier in the century, led to advances in life expectancy and reductions in mortality rates. Support continued through World War II when the draft provided a wakeup call indicating that many men were not healthy enough for military service.⁴⁹

Politics and Ideology Post WWII

Public health later weakened during the post-war economic boom, characterized by a complacent consumer culture, an exodus by whites to the suburbs,⁵⁰ market-driven health care,⁵¹ and an ideology of self-help that led people to resist social protections.⁵² The self-help phenomena derives from the long tradition of the individualistic approach to health, deemphasizing social and economic conditions and the forces that generate them.⁵³ This perspective supports a view implying that individuals are responsible for their illnesses.

The individualist legacy took new forms in the 1950s. Health departments struggled to provide basic services,⁵⁴ as funding was diverted to biomedical research.⁵⁵ Cold War era suspicion of government services and other irrational fears further silenced public health.⁵⁶ These suspicions, combined with a powerful American Medical Association campaign, ensured the defeat of the Truman Administration's proposed national health insurance plan.⁵⁷

As the leading causes of death shifted from infectious to primarily chronic diseases, public health practitioners continued to rely on the clinical model. They lacked a framework to examine and act on underlying causes that produced inequities in disease distribution, and ignored their early history in working with social reformers. Spending largely focused on personal rather than public health services.⁵⁸ The field adopted a variant of "bio-medical individualism" and linked it to epidemiology, which examined quantifiable risk factors instead of more difficult-to-measure social contexts, requiring a knowledge base outside of epidemiology. This helped make public health seem less political than it was, more technical, and less controversial.⁵⁹

A brief revitalization occurred in the 1960s with the passage of the Civil Rights Act of 1964, Medicare and Medicaid in 1966, new interests in social inequities, and the environmental movement.⁶⁰ It did not last. Most new health and social programs bypassed public health and were delegated instead to separate, newly formed government agencies. The result was the further fragmentation of public health.⁶¹ By the 1970s, individualism again became the dominant perspective, opposing a

focus on social and economic conditions. Rhetoric about personal responsibility absolved business and government entities of responsibility for the social costs of pollution, wage disparities, and unhealthy products.⁶² As the economy weakened, reducing health costs became a major national goal.⁶³ Health became more of a commodity, rather than a collective responsibility and market-based approaches became the cornerstone of future public policy.⁶⁴

This focus on cost effectiveness and the devaluation of the role of government continued during the 1980s through today. Although the Reagan administration increased the budget for the National Institutes of Health, it cut funding for many public health and social service programs.⁶⁵ The public increasingly viewed cash-strapped public health departments as agencies for minorities and the poor,⁶⁶ who were left to deal with the fallout of these cuts.⁶⁷ Tackling the root causes of health inequity was not on the agenda.

Although the Institute of Medicine during the late 1980s sought to draw attention to the role of systems and structures, reasserting public health's charge in "assuring the conditions in which people can be healthy,"⁶⁸ the country remained focused on personal behavior change. Given these obstacles, it is impressive that public health in the United States accomplished as much as it has over the last century.⁶⁹ Emerging research on the social determinants of health and health inequity, and recommendations from the World Health Organization⁷⁰ on how to confront the driving forces responsible for health inequity have illuminated possibilities for transforming public health practice. Still, expanding efforts to eliminate health inequities rather than only ameliorate their effects is difficult, as the profession faces budget shortfalls and meager public support.

Implications for Public Health Departments: Challenges and Opportunities

Still plagued by questions about its boundaries and how its mission gets interpreted and applied, public health leaders are continually negotiating the definition of public health.⁷¹ The lack of certainty results partly from the field's composition, a mix of workers from many different backgrounds and disciplines, which is both an asset and a challenge, and its long-term limited authority, scope, and political base.⁷²

The absence of a clear public narrative (stories and accounts of reality from a perspective supporting the values of social justice) allows individualism to flourish. For example, a narrative is lacking that demonstrates the deep connections among living conditions, and inequities in the distribution of disease and illness. In addition, weak ties between public health theory and practice,⁷³ and the public's seeming lack of knowledge about these connections,⁷⁴ as well as skepticism arising from an ideology that persistently denigrates the role of government, further limits progress.⁷⁵

Public health may benefit by facing these difficulties directly and recognizing its obligation to act on eliminating and preventing health inequities. Gleaning lessons from the field's late nineteenth and early twentieth-century focus on social reform and the forces arrayed against it may help move public health in this direction. Whereas the sanitary movement helped *alleviate* the conditions of poverty, public health today can advance by shifting its focus to the root causes, guided by the communities they serve.

Challenging the policies and power structures of industry and institutions to confront the root causes will no doubt involve taking great risks and enduring the pressure that comes with them. It will require cultivating long-term, sustainable support for social reforms with constituent communities. LHDs can strengthen relationships with communities experiencing health inequity, by encouraging participation in the decisions that generate health inequity, and develop partnerships across disciplines.

These objectives may seem daunting for public health departments. However, current reform efforts, recent national attention to inequality, along with extensive research on health inequity, renewed interest in social medicine and social epidemiology, and advances in practice in some jurisdictions suggest that public health may be in a position for reclaiming its place as part of a powerful social reform movement.⁷⁶ The expansion of the knowledge base of public health, the support for paid sick days and living wages, the increased public health role in land use decisions, increased attention to inequality and the examination of the health effects of home foreclosures are all major advances.

Increasing use of Health Impact Assessments (HIAs) have been an important breakthrough, with emphasis on equitable outcomes, and the potential for full participation of those likely to be affected. In addition, national efforts to develop a systems approach called Health in All Policies offer promising examples of contemporary practice examining decision making affecting health in sectors outside of public health. The latter rely on cross-sector collaborations and issues of accountability and public responsibility for health.

The more local public health can engage in sustained relations with communities and build alliances across disciplines and with social movements, the greater the opportunity for returning to a clear mission based on principles of social justice—the foundation of public health. The greatest advances in the public's health at the beginning of the twentieth century, were due to major social changes promoted by social movements, such as labor, child welfare, and voting rights for women. Public health played a major role.

Conclusion

Although public health's knowledge and data systems have become richer and more sophisticated over the years, the field's jurisdiction has shrunk. A long history of inadequate funding, statutory requirements, organizational limits, disengagement from the political system, and weak ties to community are keeping public health in the United States from being as vigorous as it could be, given its history. Interventions often tend to be reactive and narrowly focused: mobilizing in the midst of epidemics and natural or human-generated disasters and retreating later. This can change.

However, public health can use its own history as a guide to rethink its mission and goals, and to develop strategies for confronting health inequity more directly, rather than only its consequences. That mission could help public health leaders reclaim the field's social justice roots and expand them. A renewed interest in social epidemiology, a wealth of new research on social determinants of health inequity, and recommendations from the World Health Organization Commission on Social Determinants of Health have given public health leaders an impetus to reconsider possibilities. To do that will require a willingness to work closely with constituents building permanent alliances, contest contemporary ideologies, and confront directly the causes of health inequity. As historian Christopher Hamlin reminds us, "public health' is not some eternal form; what 'public' and 'health' are to be, and how they are to be related are political questions."⁷⁷ What we learn from the history of public health, applicable to today's practice, is that public health's trajectory is contingent. In reclaiming its legacy, it can again work with social reformers, this time to achieve health equity.

Notes

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7. Nathanson, *Disease Prevention as Social Change*.
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12. Clare Bambra et al. "Towards a Politics of Health," *Health Promotional International* 20, no. 2 (June 2005): 187–93.
13. Nathanson, *Disease Prevention as Social Change*, 4–15.
14. *Ibid.*, 11–19.
15. Hamlin, *Public Health and Social Justice*, 7.
16. Fee and Brown, "The Unfulfilled Promise of Public Health"; Tesh, *Hidden Arguments*, 7–32.
17. Tesh, *Hidden Arguments*, 7–32.
18. *Ibid.*, 25–32.
19. *Ibid.*, 28–32; Hamlin, *Public Health and Social Justice*, 4.
20. Hamlin, *Public Health and Social Justice*, 3–4.
21. *Ibid.*, 252.
22. *Ibid.*, 10–15;
23. Fee, "Public Health and the State," 228.
24. Nathanson, *Disease Prevention as Social Change*, 5; Fee and Brown, "The Unfulfilled Promise of Public Health," 32–33.
25. Krieger and Birn, "A Vision of Social Justice," 1604.
26. Hamlin, *Public Health and Social Justice*, 12.
27. *Ibid.*, 40.
28. Fee and Brown, "The Unfulfilled Promise of Public Health," 35.
29. Fee, "Public Health and the State," 231.
30. Nathanson, *Disease Prevention as Social Change*, 28.
31. IOM, *The Future of Public Health*, 63.
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37. Fee "Public Health and the State," 234–35.
38. *Ibid.*, 235.
39. Fairchild et al., "The Exodus from Public Health," 55.
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41. Fee and Brown, "The Unfulfilled Promise of Public Health," 37.
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44. Fee, "Public Health and the State," 244.
45. *Ibid.*, 243.

46. Ibid., 246.
47. Fairchild et al., “The Exodus from Public Health,” 57.
48. Fee and Brown, “The Unfulfilled Promise of Public Health,” 38.
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52. Dorothy Porter, “How Did Social Medicine Evolve, and Where Is It Heading,” *Plos Medicine* 3 no. 10 (2006), doi.10.1371 /journal.pmed.0030399.
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54. Fee, “Public Health and the State,” 252.
55. Fee and Brown, “The Unfulfilled Promise of Public Health,” 690.
56. Fee and Brown, “The Unfulfilled Promise of Public Health,” 39.
57. Porter, *Health, Civilization, and the State*, 229.
58. Colgrove, *Contested Boundaries*, 5.
59. Fee and Brown, “The Unfulfilled Promise of Public Health,” 690.
60. Fee and Brown, “The Unfulfilled Promise of Public Health,” 39.
61. Fee, “Public Health and the State,” 258.
62. Fairchild et al., “The Exodus from Public Health,” 59–60; Nathanson, *Disease Prevention as Social Change*, 90.
63. IOM, *The Future of Public Health*, 70.
64. Fee and Brown, “The Unfulfilled Promise of Public Health,” 41.
65. Fee, “Public Health and the State,” 258.
66. Ibid., 260.
67. Ibid., 259.
68. IOM, *The Future of Public Health*, 45–7.
69. IOM, Committee on Assuring the Health of the Public, 73–74. Working with community activists, public health helped to institute seat belt and food labeling laws and pushed for increasing restrictions on tobacco companies, both of which have resulted in improved health outcomes for hundreds of thousands of people. Public health has been instrumental in uncovering the benefits of fluoride to dental health, moving forward regulations that have dramatically reduced childhood lead poisoning, bringing intimate partner violence into public dialogue, and more recently, highlighting the contributions of the food and beverage industries to the growing obesity epidemic. In some jurisdictions, it has demanded that the use of Health Impact Assessments for social policies that carry obvious health implications.
70. WHO, Commission on Social Determinants of Health, *Closing the Gap in a Generation* (Geneva: WHO, 2008).
71. Colgrove, *Contested Boundaries*, 3.
72. Fee and Brown, “The Unfulfilled Promise of Public Health,” 32.
73. Ibid., 691.
74. IOM, *The Future of Public Health*, 23.
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Essay 3 | Racism and Class Structure

Part I: Structural Racism

Introduction

Strongly shaped by class and gender inequity, structural racism is a fundamental cause of health inequity, associated with imbalances in political power throughout society.

Paraphrasing Lawrence and Keleher,

Structural Racism in the U.S. is the normalization and legitimization of...a system of [reinforcing] historical, cultural, institutional, and personal hierarchy and inequity, primarily characterized by white supremacy that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color. Its manifestations include our history, culture, politics, economics and our entire social fabric.¹

Structural racism functions through the life course in all of society's structures constituting the social and economic system (housing, employment, education, health, criminal justice, etc.), which support or sustain racial inequity. It exists when society enables and reproduces differences in people's access to resources, opportunities and power, based on race.²

Not simply another factor in a list of social determinants, structural racism is a core social injustice. More important is to consider "the socio-historical processes by which racial categories are created, inhabited, transformed, and destroyed."³ To understand how life chances relates to racism, Bonilla-Silva argues that in order not to "[obscure] the social and general character of racialized societies [and systems]" it is necessary to consider racism through "the totality of...racialized social relations and practices" in the overall racial structure of a society that plays out in specific conflicts of interest.⁴

John A. Powell's description of racialization captures the idea succinctly:

“Racialization” connotes a *process* rather than a static event. It underscores the fluid and dynamic nature of race. Moreover, “racism” is understood as a consciously motivated force. “Racialization” implies a process or set of processes that may or may not be animated by conscious forces.⁵

The importance of these distinctions is related to strategies for ending racism. Because structural racism is part of an embedded system of racialized relations and not merely wrong attitudes, education is not a solution.⁶ This has implications for public health practice.

Patterned racial inequities in health outcomes today are significant and increasing, reflecting broader patterns of social and economic inequalities. Whites, as a group, experience better health. African Americans tend to have an average of 2.5 times the infant mortality rate of Whites.⁷ Their life expectancy is four or five years less than Whites. As Williams and Mohammed indicate, “Racially stigmatized and disenfranchised populations have worse health than their more advantaged counterparts. [Their] poorer health is evident in higher rates of mortality, earlier onset of disease, greater severity and progression of disease and higher levels of comorbidity and impairment.”⁸ Latino Americans tend to have worse health the longer they remain in the United States. In many jurisdictions, their health is affected by poor working conditions, anti-immigrant local laws that exclude the receipt of social benefits, and the stigmatization of day-to-day experiences.⁹ Patterns of ill health among Native American populations, although varying across tribes, tends to be worse than Whites.¹⁰ Although populations of color with low-income and less education fare worse, the distinctions are persistent among people of color at all education and income levels.¹¹ Questions raised are how and why health inequities arise in the first place and what are their specific connections with structural racism?

This essay explores features of the historical legacy of racial oppression, solidified in laws and practices that continue to shape the experience of people of color, resulting in poor health outcomes. It examines how structural racism—rather than race itself—continues to harm health, paying close attention to its many dimensions. And finally, the essay concludes by discussing the implications of its legacy for public health practitioners and organizations seeking to achieve health equity.

Manifestations and Persistence

In 1890, San Francisco enacted an ordinance requiring all Chinese residents to relocate to a segregated area of the city. They had six months to comply or face imprisonment.¹² In 1912, a Nebraska state statute made it illegal for any White person to marry any person

of color: Black, Brown, Yellow or Red.¹³ That same year, a residential statute in Virginia ordered cities to draw up segregation districts, claiming that mixed-race neighborhoods would endanger “public morals, public health and public order.”¹⁴

In 1956, the city council in Huntsville, Alabama, enacted an ordinance outlawing basic social interactions: Black citizens and White citizens, for example, were not allowed to play checkers, dominoes, or other games together.¹⁵ And just two years later, in 1958, a health care statute from nearby Louisiana stated that all human blood intended for transfusions must be labeled by race.¹⁶ These few examples represent the hundreds of Jim Crow laws enacted in both the North and the South between the 1870s and 1960s that mandated racial segregation in public places and facilities including schools, transportation systems and restrooms. Such laws, enacted at both the state and local levels, conferred a “separate but equal” status on African Americans and other people of color, preventing them from sharing the same space, rights, and degree of freedom and respect. People of color were forced to attend separate schools, live in separate neighborhoods—even be buried in separate cemeteries. Violators were often fined, jailed, or killed.

Yet Jim Crow, more than a collection of legal restrictions, was also a way of life. It structured people’s experiences and defined their identities. It reinforced the concept of race as a constant, natural, biological phenomenon, rather than a constructed category.¹⁷ It provided individuals and institutions from churches to the judicial system and health care system a rationale for allowing White people to reap the benefits of their privilege with a clear conscience. Those benefits included advantages in housing, employment, health care, and political representation, to name a few.

Since Jim Crow’s legal demise in the 1950s, its legacy persists in insidious ways throughout the country. Voter identification laws represent a recent example.¹⁸ According to civil rights scholar Michele Alexander, Jim Crow-like racial control still exists but in a different form: the prison system. People of color, especially young Black men, experience higher rates of incarceration than Whites, often receive harsher sentences for the same crime, and systematic exclusion from juries. Disenfranchisement doesn’t end once incarceration ends.¹⁹ In many states, they suffer a permanent loss of voting rights. Such disadvantages have cumulative effects over generations.

Today, restricted education and work opportunities have led to a lifetime of low earnings and high rates of poverty for many people of color. Black Americans, for example, make less than 60 percent the income of White Americans, and a third of the Black workforce takes home less than \$385 a week (\$20,000 a year) before taxes.²⁰

Manifested through systematic social exclusion, marginalization, and powerlessness, structural racism restricts the possibilities for a flourishing life and well-being. Structural racism perpetuates housing and educational segregation, concentrated poverty, failure to invest in communities of color and locating toxic waste, landfills, and polluting factories predominantly in low-income communities of color.

Structural Racism: Segregation and Land Use Practices

Sustaining racial hierarchies functions within hundreds of routinized practices, uncritically accepted and unacknowledged. Practices that perpetuate residential segregation in particular continue to influence everything from where people live and their mobility to their wealth and to their likelihood of experiencing exposure to specific types of environmental pollution. Contemporary practices like predatory lending, whereby banks target communities of color with costly subprime home loans, have sustained patterns of segregation. Similar to the 1960s practice of redlining, which restricted homeownership opportunities based on race, predatory lending has priced many people of color out of the housing market.²¹ Evidence of racist lending practices, which contributed to the 2007 collapse of the housing market, continues to surface.²²

In addition, neighborhoods where most residents are White have a higher value in the housing marketing than neighborhoods where most residents are not. This results in White homeowners receiving larger returns on their investments and higher levels of wealth than African Americans,²³ the most racially segregated group in the United States.²⁴

Evidence of residential segregation occurs through suburbanization, which has historically given White people the opportunity to live in well-resourced, affordable neighborhoods and relegated many people of color to city centers and other undesirable residential areas, where prices are often higher and government investment is lower.²⁵ Without investments, many urban neighborhoods have seen their businesses, transportation systems, educational systems, and other infrastructure deteriorate. However, in recent decades, suburbanization has given way to gentrification, with Whites moving back into or close to cities. As higher-income (and typically White) residents rent or buy real estate in these blighted areas, prices rise for everything from property to local business products, making the area less affordable and pushing out people of color.²⁶

For most people living in the United States, residential location determines the availability of public school options, jobs that pay living wages, and access to local services such as affordable medical care.²⁷ For example, residential segregation leads to segregated education systems, with Black and Latino students being concentrated in urban schools that have “inferior courses and lower levels of achievement” than adjacent suburban schools available primarily to White students.²⁸ Such segregation limits educational opportunities, which are key to high-paying entry-level jobs.

Some corporations use a community's racial composition to determine where to build their offices, further restricting access to well-paid work²⁹ when they site their businesses in predominantly White areas. Additionally, because political leaders typically spend more money to help maintain the infrastructure of affluent areas where large numbers of White people live, neighborhoods with high minority populations often have lower quality housing and fewer social services.³⁰ They also tend to have few full-service grocery stores selling fresh, healthy food options and an abundance of convenience stores and fast food restaurants that carry foods high in fat, sugar, and salt.³¹ Marketers of alcohol, tobacco, and junk food saturate these communities with billboards,³² increasing people of color's exposure and susceptibility to harmful products.³³ Because accumulated disadvantages have led residents of poor, segregated neighborhoods to have less political power to influence elected officials, they have fewer means to realize change.³⁴

Many corporations exemplify structural racism by siting toxic waste dumps and other polluting facilities in White communities far less frequently than in communities of color. For example, a 1987 study of uncontrolled hazardous waste sites in major U.S. cities showed that "communities with the greatest number of commercially hazardous waste facilities had the highest composition of racial and ethnic residents.... Three out of every five Black and Hispanic Americans lived in communities with uncontrolled toxic waste sites."³⁵ This was true even controlling for socioeconomic status. A follow-up report 20 years later confirmed these findings and worse.³⁶ (Not surprisingly, West Harlem in New York City has the highest asthma rates on the East coast, given it houses three-quarters of Manhattan's polluting sites.³⁷)

Although race, education, income, and wealth are connected, the quality of segregated communities and the ability of people of color to better their lives is not simply a function of socioeconomic status. Black individuals, for example, don't see the same rewards for economic or educational success as their White counterparts.³⁸ A 2003 study in Milwaukee, Wisconsin, found that White job applicants were more than twice as likely to be invited to a job interview as equally qualified Black applicants.³⁹ African Americans also experience lower neighborhood quality at every level of socioeconomic status. Middle-class African Americans, for example, are more likely than middle-class Whites to live in places with neighbors who are less affluent than they are.⁴⁰

The Link to Individual and Internalized Racism

Although structural racism is at the root of race-based inequality, it functions at the individual and psychological levels, which harm health. Individual, or personally mediated, racism involves differences in both attitudes and actions toward others, but recall that at its root it is not *per se*, based on skin color. People express it through lack of respect (e.g., poor service in restaurants or retail stores), suspicion (e.g., heightened vigilance

from storekeepers), devaluation (e.g., showing surprise at someone's competence), and dehumanization (e.g., hate crimes).⁴¹

Although overt acts of racial discrimination have seemingly been on the decline, racial stereotypes persist, enduring effects of early experiences remain, and persistent structural racism continues to create stress. This holds true even after accounting for people's reluctance to report negative social attitudes and the tendency of more socially advantaged groups to deny that discrimination exists.⁴² The dominant ideology of individualism blames people for the struggles they face, and ignores "cultural and structural causes for racial differences" in health outcomes and prescribes increased personal responsibility as the solution.⁴³

Health Consequences of Racism's Many Dimensions

"Culture," writes evolutionary anthropologist Robert Boyd, "is as much a part of human biology as the enamel on our teeth."⁴⁴ And for people of color, years of deprivation and disadvantage related to racism are a large part of that culture. This deprivation can write itself onto the body in the form of heart disease, high blood pressure, cancer, type 2 diabetes, osteoporosis, multiple forms of violence, and many other illnesses. It can even lead to early death.⁴⁵ According to Galea, over 176,000 deaths can be attributed to segregation each year.⁴⁶

Researchers have proposed possible pathways for these health harms including chronic stress, which can interfere with the body's ability to fight disease⁴⁷ and chronic vascular inflammation, which decreases immune function.⁴⁸ The effects of discrimination and the threat of discrimination can lead to increased vigilance and therefore emotional states resulting in poor health. But regardless of the exact mechanism of biological expression, one thing is certain: Racial or ethnic differences in health outcomes have social and political, not genetic, origins.⁴⁹

Take, for example, the Latino paradox—an epidemiologic finding that Latino immigrants to the United States, as a group, have better health and longer lifespans than native-born Latino Americans, despite being poorer and less educated. Yet the longer Latinos stay in the United States, the more likely they are to experience health declines and develop many of the same chronic conditions common among lifelong residents.⁵⁰ This is partly explained by the greater the acculturation to U.S. characteristics related to things like smoking, the pace of life, and leisure activity. Within five years of living in the United States, Latinos are one and a half times more likely to be obese or develop high blood pressure,⁵¹ and within a generation, their health is as poor as that of other people of color who were born in the United States.

Another telling example comes from southern Arizona's Tohono O'odham Nation, also known as the Pima Indians, who have the highest known rate of diabetes in the world. A hundred years ago the Pima were healthy, untouched by diabetes. Since then, however, a major political event led to dispossession of their land, water, and culture: In the 1890s, the U.S. government diverted the Gila River, the Pima's main source of water and money, making it available to White farmers and settlers upstream. Without the river, the Pima Indians were unable to grow healthy, natural foods or maintain their agriculturally based economy. For generations, they were forced to rely on government-subsidized processed foods high in fat, calories, and carbohydrates. Poverty rates soared. Unsurprisingly, so did obesity and diabetes.⁵² After a protracted legal battle, the government restored the Pima's water in 2004, and health and political leaders alike are hopeful that their health will eventually recover.

During the civil rights movement, as Black Americans gained legal rights and social power, they also experienced health improvements, and Black-White disparities for many causes of mortality decreased. However, this progress in health was short-lived. As the political climate changed in the 1970s and 1980s, Black Americans saw their health worsen, and by 1998, their mortality rate had risen to one and a half times that of Whites—the same that it had been in 1950.⁵³ This pattern of losing previous health gains appeared in Black infant mortality rates too, which, by 1998, exceeded pre-civil rights levels.⁵⁴ Noting how political power affects disease rates and well-being, these findings indicate the centrality of collective resistance to powerlessness in improving health.

In addition, these findings, along with much other research, suggest that although racism always intersects with socioeconomic position and gender, it still can have independent effects as a social determinant of health inequity in itself.⁵⁵ It is another layer of social inequality that disadvantages people of color not only by depriving them of material resources but also by limiting their power to shape public discourse, politics, and institutional policies and practices.⁵⁶

The effects of structural racism begin at an early age, sometimes even in utero, and affects health outcomes throughout life, documented in differences between Black and White birth outcomes.⁵⁷ Black women are twice as likely as White women to have preterm or low birth weight babies⁵⁸ regardless of socioeconomic status.⁵⁹ Thus, for all their benefits, increased education and increased income cannot fully counteract the health effects of racism. The overall health of Black Americans is worse than that of White Americans at all levels of income.⁶⁰

Conceptualizing Racism in Public Health

Racism can also drive health inequities through its affect on epidemiology and public health practice.⁶¹ The questions researchers ask, the studies they conduct, how they interpret data, and how they conceptualize both “race” and “racism” all affect how the public interprets the causes of differential outcomes between Whites and people of color and what actions people ultimately take to improve health. For example, despite overwhelming evidence that racism, not skin color itself, is a determinant of health, biological markers of race and biological expressions of racism still often get conflated.⁶² In particular, much epidemiologic research continues to cast race as an independent, biological variable,⁶³ diminishing its historic and social nature.⁶⁴

Sometimes scientists conceptualize racism too narrowly.⁶⁵ For example, racism is often described in relation to irrational prejudices or overt, hateful behaviors rather than as a structural force that benefits some groups by disadvantaging others. For example, segregation is not necessarily based on prejudice; it may result from viewing communities of color as disposable. This occurred after WWII when housing policy, lending practices of banks, and real estate interests helped to create urban ghettos.⁶⁶

Racism is also commonly portrayed as a static product of the past, even though it is dynamic and changes with contemporary social systems and structures.⁶⁷ For example, since 2007, millions of Americans have lost their homes⁶⁸ largely as a result of lenders systematically targeting low-income communities of color with subprime mortgages.⁶⁹ And in 2011 and 2012, many states enacted laws limiting people’s voting ability by reducing early voting periods, requiring government-issued photo identification, and other restrictive measures.⁷⁰

Thinking of racism as static can lead to racial inequalities not directly tied to an act of discrimination to go unacknowledged.⁷¹ Additionally, explanations that do not include its political aspects may be harmful. They may foster an inadequate conception of its structural elements and thus potentially generate inaccurate approaches for action. Public health language often describes the environment as the source of inequity. But words like “environment” are neutral and suggest that inanimate objects or conditions—rather than power relationships among people—underlie racial oppression.⁷²

Implications for Public Health Practitioners and Organizations

Public health departments can play a significant role by focusing attention on structural racism by examining how racism creates and perpetuates health inequities. In doing so, they will gain a more complete picture that can lead to more effective strategies to guide action. Rather than considering race as a biological category, health departments, recognizing the structural character and effects of racism as a constructed category, will be better prepared to consider systemic changes.

Public health departments can also consider practice beyond individual programs and services or even individual policies, by directing attention to the systems and structures that foster racial and health inequities. This would require capacity-building and preparing staff for their evolving roles, through anti-racism training in their departments. Health departments in Michigan's Ingham County, California's Alameda County (ACPHD), and Boston, among others, have begun this process.

In Alameda County, California, for example, the department's leadership works to ensure that all employees from line staff to directors are educated about the social determinants of health inequity and its root causes. ACPHD hosts a monthly discussion group on equity and uses its website to promote resources, such as the documentary series *Unnatural Causes: Is Inequality Making Us Sick?* that explores the health consequences of racism in depth.

Boston's Public Health Commission leaders have developed an institutional framework for promoting health equity, which includes concerted efforts to "oppose discrimination and racism in all settings." Boston's framework includes improving institutional competency by "providing employee education and training opportunities" and "identifying and changing internal policies that may perpetuate inequities"; supporting and building "community capacity to lead and engage in efforts to eliminate inequities"; and identifying "partnership opportunities to enhance and promote efforts to eliminate inequities." Using this framework, Boston has outlined a series of specific goals and health outcomes it wants to realize by 2016, including reducing disparities in low birth weight by 25 percent.⁷³

Ingham County's ongoing dialogue process offer employees the opportunity to recognize how privilege affects disadvantage in the workplace and community. Seeking to overcome the reinforcing power of the dominant culture in its avoidance of racism, their process has led to long-term results in the way staff challenge assumptions and pose questions about conventional practice. Essentially, the principles of social justice become embodied in everyday work, rather than following a set of prescriptions or models for action. Ways of interacting with community residents and attentiveness to institutional decisions have become salient, leading to an emphasis on root causes, even though formal metrics cannot be applied.⁷⁴

In conducting this work, internally attending to personal growth is crucial as people engage personally. Building authentic relationships cannot be overlooked because the process is not only about policies and procedures. The goal is advancing structural change and no clear model can be applied because the process is partly improvisational and experiential. Some of that work begins with the equitable provision of high quality services.

Conclusion

Structural racism dates back to slavery, and is perpetuated by residential and educational segregation, employment discrimination, violence, and disenfranchisement. It isolates people of color and unfairly privileges their White counterparts, thereby limiting access to the resources and systems that could supposedly democratize opportunity and give everyone a solid start in life. The reach of racism is profound; its ability to thwart life chances and harm health is alarming. Public health departments can be a part of today's movements for social change. Many already are by illuminating the serious effects structural racism has on health and working to disrupt it within their agencies and by collaborating with those they serve. They are beginning to examine the political, macroeconomic, and contextual forces, including power arrangements that perpetuate health inequities.

Part II: Class Structure

Introduction

Every society has class distinctions in which one or more social groups dominate others. For example, caste systems (India), slave systems (the United States before the Civil War, ancient Greece and Rome), the feudal system in the Middle Ages, and—less overtly than in earlier times—Europe and the United States today. Class in modern times, linked with racialized and gendered categories, has always been a contested and varied concept.⁷⁵ In public health, primarily associated with personal attributes such as income, social status, and occupational position, it is an important indicator linked to questions about health outcomes.⁷⁶ Population measures of income inequality reveal a good deal about trends in the growth of inequality, its severity, and effects on health and well-being.⁷⁷ Public health relies on extensive research demonstrating the connection between socioeconomic status and health in designing programs, services, and policy. That knowledge has supported efforts to champion advances leading toward living wage, paid sick days, affordable education, and job training, among others, to improve people's ability to live well and be healthy.

But this concept of class, emphasizing individuals' location within society's economic hierarchy, does not consider causal mechanisms—what produces inequality in income, wealth, status, or the relations between class positions.⁷⁸ Nor why those variations may be unjust and how they occur. We want to understand how inequalities in life expectancy and health outcomes flow from these variations. Equally important is to identify

the transformation needed to eliminate health inequities. Reducing the permanent marginalization and social exclusion of large segments of the population requires more long-term strategies linked to social change.

Exploring the full implications of class can guide the understandings of causal mechanisms and strategies for practice. Recognizing class as a structure of economic and social power, associated with major cleavages in society that generate recurrent conflict, rather than as a status, can facilitate that effort. Given the goal of preventing the perpetuation of health inequity, an investigation of how health inequity arises from society's class structure may inform a reevaluation of some features of public health practice. This would include strategies directed toward eliminating, rather than only treating, the effects of health inequity. Specifically, they would address structural reforms to ensure a political process more accountable, transparent, representative, and participatory.

This essay analyzes some ways in which class structure and the mechanisms through which it functions produce and reproduce health inequity. It clarifies the relevance of class for public health practice and asks how local public health departments can begin to disrupt and eliminate health-harming processes generated by class structure, even in small ways, as a root cause. Such a more fully developed conception stresses collective forms of action for meeting human needs, not typically considered in conventional practice. It may explain, for example, why inequity cannot be reversed by changing individual behavior but potentially can be addressed instead by directly addressing marginalization, deprivation, and social exclusion experienced by particular social groups.

What is Class?

In this perspective, class structure refers to features of a society's social and economic structure associated with the politically organized power of networked, well-resourced social groups with common interests.⁷⁹ Such groups are able to influence society's major institutions and the uses of productive resources (e.g., education, communications, housing, technology, transportation, investments, banking and credit, the labor process, and labor conditions).⁸⁰ These networked groups engage in efforts to direct not only the economy but most aspects of social life that influence living and working conditions. Within the present structure in the United States, public and private decision-making processes often lack accountability, oversight, or full participation by the citizenry.

The interaction among classes is referred to as class relations. The balance of power within class relations determines agendas, priorities, and the rules of the political system, including public health. However, resistance to and contradictions within these efforts offer possibilities for change; the class structure is not immutable. Class relations, always thoroughly interwoven with issues of racism and gender inequity, together establish the

structural determinants of health inequity.⁸¹ According to the World Health Organization framework, “Structural determinants [of health] are those that generate or reinforce social stratification...and...define individual socioeconomic position. These mechanisms configure the health opportunities of social groups based on their placement within hierarchies of power, prestige, and access to resources.”⁸² Knowing why and how some social groups accumulate different levels of resources, power, and prestige can provide guidance for action on health inequities that primarily result from decisions by the groups that have the most power.⁸³

Why Class Structure Matters for Health

Class influences the decision patterns that create negative outcomes in life chances for particular groups.⁸⁴ The result, over time, has been persistent patterns of advantages and disadvantages in mortality, morbidity, and life expectancy affecting biological development throughout life. An accumulation of negative health effects occurs either directly (e.g., through exposure to pollution) or indirectly (e.g., through exposure to stress resulting from poverty or institutional racism). These outcomes limit the ability to realize fully human capabilities.⁸⁵

Class also influences the degree to which social injustice becomes institutionalized or more firmly rooted, as manifested through deepening interconnections among racism, poverty, gender inequity, and homophobia.⁸⁶ One example occurs within the labor process, whereby one class decides the nature of labor contracts and working conditions.⁸⁷ A goal for public health is to discover ways to influence the configuration of class power by diffusing and democratizing it.

Powerlessness (the absence of political equality), for example, makes people sick.⁸⁸ Therefore democracy, (effective participation in the decisions that affect the economy, accountability, and transparency, along with values of cooperation, reciprocity, and social obligation) is important to health and well-being.⁸⁹ If public health is to prevent health inequity and not only treat its results, strategies would emphasize the processes that reproduce the power relations, rules, and institutional practices that perpetuate the existing class structure, even if incrementally. For example, the link between socioeconomic status and health varies based on a country’s level of democracy and also appears to be more closely tied to poorer health in nations, such as the United States, that have weaker social welfare systems.⁹⁰ Since 2000, comparative social epidemiology and health policy research has demonstrated consistently that better health outcomes appear in social democratic welfare states, where governments have a larger role than the market in providing goods and services.⁹¹

Three Scenarios about Class Power

Consider three scenarios that represent the expression of class power:

- ◆ Thousands of jobs are moved overseas, as a means to create a more flexible, low-wage, part-time workforce without benefits, with limited health and safety or labor market regulations and little need for collective bargaining. This leads to job insecurity and a poorer quality of life.
- ◆ A large real estate firm, with large local tax credits and incentives, receives loans from a group of banks to purchase land and equipment to build a 40-story office building as a means to increase rents, requiring the displacement of thousands of long-time residents, disrupting community life, and creating high stress levels.
- ◆ A large number of targeted sub-prime mortgage loans are made in low-income communities as part of a process that leads to the greatest economic crisis and number of home foreclosures in the United States since the Great Depression. Entire communities experience harmful effects as services decline. The crisis creates overwhelming trauma and loss, disrupting peoples' lives, disintegrating their communities, and leading to homelessness and loss of income, including the long-term effects from decreased intergenerational wealth. In Alameda County, California, foreclosed residents were “more than twice as likely to experience problems of stress, depression or anxiety, compared with those not foreclosed.”⁹²

These decisions exemplify the legal uses of organized networks of concentrated class power that shape society. Often routine decisions can inherently create staggering degrees of wealth and income inequality but also deprivation, marginalization, and dislocation in peoples' lives. The results cause permanent damage to communities.⁹³

Such outcomes are not primarily the result of failed policies, bad people, or failures and inefficiencies of markets. Rather, they are related to characteristics of the class structure. Efforts to reduce inequalities cannot occur primarily through either piecemeal solutions or through expanded economic growth, which itself can exacerbate inequality.

Examples of Class Power Affecting Patterns of Population Health

The decisions below exemplify the uses of power through class structure that significantly affect the health of large population groups. These kinds of decisions rarely occur in open, public forums. Consider how public health might play a role with others in affecting these examples.

Land Use

- ◆ **Gentrifying neighborhoods**, causing the destruction of a way of life and dispossession for whole communities beyond disease and illness, to loss of culture, livelihood, social connections, social services. Such trauma can last for generations.⁹⁴

- ◆ **Enabling residential and educational segregation**, by excluding some populations from access to resources, shelter, a stable ecosystem, and full participation in mainstream social and political life.
- ◆ **Ignoring public health in economic development.**⁹⁵

Democracy

- ◆ **Limiting oversight/regulation** of financial institutions to protect the public creates severe crises and trauma for millions of people during the recession of 2008–2010, especially those who are poor, people of color, and women.⁹⁶
- ◆ **Limiting public control of decision-making** through privatization for formerly public goods and services such as prisons, schools, and public health agencies.
- ◆ **Restricting the use of class action lawsuits to protect health.**
- ◆ **Privatization of state and local government functions.**

Labor and Labor Markets

- ◆ **Shifting jobs and capital overseas** or out of state generating extensive unemployment and social dislocation, which disrupts stable social life, and lowers wages, as people must change jobs more often without long-term planning.
- ◆ **Falling value of minimum wage.**
- ◆ **Changing tax rates and tax rules that harm those with lower income.**
- ◆ **Speeding up the work process and pressure for greater productivity.**

Ecology

- ◆ **Increasing carbon emissions leading to global climate change and avoiding action to reduce its impact.**
- ◆ **Increasing extraction of polluting, non-renewable resources.**
- ◆ **Targeting communities of color for the location of hazardous waste.**⁹⁷

The linked decisions above represent daily examples that negatively affect public health and well-being. Power of this magnitude affects everything from the food people eat to air quality to availability of job opportunities in different regions—all of which have effects on health.⁹⁸ Limited liability laws prevent accountability for the social, environmental, and health harms.⁹⁹

Although people do not experience macro-level power relations directly, those relations determine life chances as they play out in labor markets, educational systems, and so forth. However, power relations and institutional rules can change.¹⁰⁰ The civil rights, labor, and women's movements exemplify how groups can and have shifted power dynamics.¹⁰¹

Obscuring Class: Implications

The evasion of class structure has had important implications in constraining effective approaches to health inequities. Engaging discussion on class structure's influence on health outcomes is challenging, given widespread, pervasive misconceptions, especially that class does not exist. The denial of class, for example, limits the explanation for social and economic inequalities to the mechanics of natural economic laws or unpredictable forces, whereby power privilege and interest disappear. Explanations typically emphasize the shift to a service economy, technological changes, and the internationalization of financial markets. Solutions to inequality highlight social cohesion, building community, or good behavioral choices rather than broader social change.

Class, when interpreted as an individual attribute or status is akin to rungs on a ladder that individuals can climb or descend at will, making class relations, and the patterned forms of exclusion and marginalization they produce, invisible. Although income and wealth disparities or occupational status may predict health outcomes, they are less helpful for exploring their generation.

All too often, class appears as a natural state of affairs.¹⁰² Reports in the mass media often describe the “gap” between the rich and the poor and references to wages rising or falling, as though they occur without human agency.¹⁰³ A common belief in the United States is that a combination of talent, luck, and hard work are all people need to achieve economic success.¹⁰⁴ This belief resists facts about class mobility, even when data show otherwise. Less than one-third of Americans eventually leave the economic starting point into which they are born¹⁰⁵ and that mobility appears to be diminishing over time.¹⁰⁶

Finally, even when exposed as the product of concerted decision-making, class remains under-investigated, its source presented as undiscoverable and unimportant.¹⁰⁷ As difficult as it is to engage in a sustained and thorough discussion of class, those who attempt it typically do so with at least one idea in common: A recognition that the inequality class structure produces is harmful to health and well-being. How can health departments take that recognition and leverage it to reveal and act on the explicit role that class structure and the relations that flow from it play in harming health?

Reflections on the Potential Role of Local Public Health

Whether this perspective on class can be helpful to public health practitioners depends on accepting two assumptions. First, tackling the roots of health inequity implies an expansive conception of practice. Similar to responses to global climate change, containment strategies can only succeed for so long. The boundaries of legitimate practice may need to match the true nature of health inequity. Second, conventional methods may not be effective. Retaining the technical, professional definitions and categories in public health, established by organizational needs of bureaucratic agencies, may not be

sustainable against such persistent inequality. The numerous patterns of decisions made every day that place the common interests of large segments of humanity at risk from stresses associated with insecurity and lack of well-being require concerted action. Local public health can play a critical role in its response, with respect to the choice of research questions, potential agendas, priority setting, and strategies, even if only to begin by informing the public of the implications. What actions might be taken?

First, public health practitioners can educate the public about the need for living wage and paid sick leave, and also support the idea of social investment in education, local urban and rural infrastructure, and life enhancing public resources.

Second, they can investigate or collect existing information about the institutions that generate the conditions described above, by directing attention toward the patterned processes that continually produce health inequity. They can attempt to describe trends from existing knowledge, in order to predict likely health outcomes from economic and social policy decisions and inform the public of the role decisions play.

Third, as a result of the first, they will be able to anticipate and respond to the health inequities produced both by occurrences such as economic crisis and the seemingly ordinary workings of the economic system. Foreclosure, for example, has had a severe effect on health in many communities, as noted.

Fourth, in line with the previous comment, local public health practitioners can explore strategies to act early in potentially health-harming decision making, through the use of health (equity) impact assessments, and otherwise express their authoritative knowledge about health effects of social policy.¹⁰⁸

Fifth, practitioners can also become involved in and engage with the public in decision making and planning within their own departments, specifically with communities most affected by conditions that produce health inequities.¹⁰⁹

Sixth, they can build solidarity with allies, chosen much more strategically, enabling collective action with other health departments and eventually with other local government agencies. WHO argues for “shared power and altering social hierarchies in the direction of greater equity.”¹¹⁰

Finally, public health practitioners can devise a compelling public narrative for health equity, in part to counter the dominant narrative. It can, for example, express how public health enables people to live a flourishing existence and exercise their creative human potential, by providing access to the physical and social conditions for health. Such a narrative affirms the connections between health and living conditions and peoples’ real interests and needs for well-being.

Conclusion

Class structure determines societal power relations. It is important to document the links between causal mechanisms that express power relations and health outcomes through everyday micro-level processes. These social relations, embedded in everyday life, work to the social and economic advantage of some people and to the disadvantage of others. Beyond issues of distribution, class concerns the power to direct the use of society's resources and investments that determine how a society organizes itself and in whose interests. Exploring the workings of class structure, including its contribution to socioeconomic status, is critical to developing effective strategies for eliminating health inequities. Realistic strategies are possible because class relations are not fixed but fluid and contingent. Their configuration always results from the outcome of conflicts, opening the space for change. Eliminating health inequity, which depends on living conditions that enhance well-being and the quality of life, requires engaging with a wide range of linked issues. Such issues, from racism to gender inequity to ecological health are not autonomous from larger struggles for social transformation. Successful transformations in the past were associated with movements that place the interests and objectives of ordinary people in achieving health and meeting basic needs in the forefront of public health's objective, thereby returning it to its roots in social justice.

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Essay 4 | Knowledge for Health Equity: Frameworks and Process

Introduction

The knowledge base and framework necessary to investigate the root causes of health inequities often take local health departments (LHDs) into unfamiliar territory. These inequities are strongly related to social and economic inequalities.¹ The collective experiences of populations marginalized by their subjection to health-harming life conditions shape their patterns of health outcomes, sometimes for generations.² Identifying and interpreting the patterns of accumulated institutional decisions that repeatedly produce health inequities depend on numerous information sources from many disciplines over time. How can LHDs and other public health practitioners more effectively gather, analyze, and present information about the causes of health inequities, so they can improve their practice to act on the roots of health inequity?

The required knowledge base will likely rely not only on expanded view of relevant evidence but varied types of reasoning.³ This work may include becoming more aware of the theoretical frameworks that guide decisions, and ways of knowing beyond epidemiology, or even science. Equally important is co-creating knowledge with constituents, as part of planning, implementing, and evaluating efforts toward eliminating health inequity.

This essay seeks to raise awareness and poses questions about the knowledge base for health equity. The purpose is to enable LHDs, as they engage in inquiry, to identify and act more effectively on the causes of health inequity. We explore two central issues. The first concerns the relevance of the frameworks, concepts, and questions chosen. The second considers how and why practitioners can build relationships and work with their constituents in the pursuit of knowledge. The standpoint of those experiencing inequity is central to determining what may be relevant for guiding action. Before examining these issues, we describe opportunities for advancing a knowledge base within public health, followed by ongoing constraints within dominant perspectives and their effect on practice.

Growing Support, Legitimacy, Resources

Since 2000, many public health practitioners have witnessed a growing interest in applying a framework grounded in principles of social justice. The WHO's Commission on the Social Determinants of Health recommended examining the social structures and political processes (public and private) that generate health inequities.⁴ Since the late 1980s, an explosion of research on health inequity, within various theoretical frameworks repeatedly documents the social, economic, and political influences on population health outcomes.⁵ Much work emphasizes the ways underlying structures produce patterns of inequality that create health inequity.⁶

A series of national and international reports have brought attention to health inequities and documented the mechanisms that create them. They include the Institute of Medicine Reports on the future of public health,⁷ the Black Report in Great Britain,⁸ the Ottawa Charter in 1986,⁹ the 2008 Report of the WHO Commission on Social Determinants of Health, along with the discussion papers that followed that report over the years;¹⁰ and the Millennium Development Goals,¹¹ among others. In addition, numerous insightful books have appeared over the years, highlighting elements of racism, class, and gender inequity that generate health inequities.¹²

Many resources have become available to LHDs for purposes of support, technical assistance, education, assessment, and analysis of community health. For example, the Bay Area Regional Health Inequities Initiative (BARHII) has designed a self-assessment toolkit for LHDs “to assist in their development of a great capacity to address health inequities [and] guide the development and implementation of strategies that move the department's work in that direction. The analysis and results can also serve as ongoing measures to identify the LHD's progress towards its goals developed through the assessment process.”¹³ The PBS documentary series from California Newsreel in 2008, *Unnatural Causes: Is Inequality Making Us Sick*,¹⁴ widely seen and discussed in the public health community and viewed by millions across the country, sparked almost 150 town-hall events sponsored by state and local health departments.

The Public Health Accreditation Board (PHAB) in 2012 determined that it would identify the relationship between PHAB standards and measures and health equity, in order to evaluate concepts and “non-public health specific data and issues” that would deliberately strengthen PHAB's guidance for health department documentation related to health equity, including strategies to ensure that PHAB appropriately emphasizes health equity in its accreditation materials.¹⁵ NACCHO produced a multimedia free web-based course in 2011 that prompts participants to reflect on how institutions structure the possibilities for health and wellness.¹⁶ Researchers, such as Nolen et al.,¹⁷ have documented approaches for determining the kinds of databases necessary for institutionalized monitoring health equity/inequity.

Dominant Perspectives Influencing Frameworks and What Counts as Legitimate Knowledge

As noted earlier, much has been known for a long time about the effects of social and economic inequality on health.¹⁸ Often, however, efforts by LHDs to consider the underlying mechanisms that generate inequalities are seen as unrealistic, because economic arrangements are perceived as inevitable or beyond the scope of their practice. This view exemplifies an often dominant perspective that influences the frameworks and concepts with which to investigate health inequity. In these perspectives, health inequities are sometimes understood as “externalities” or side effects of a lack of resources that reflect taken-for-granted inequalities in power.¹⁹

Numerous forces at work simultaneously limit LHDs from directing their work toward root causes and the structures and decision processes that generate health inequity. The first is attributing health problems to individual choice, behavior, and lifestyle, partially due to the traditional biomedical model, linked to disease specific incidence and focusing mainly on genetics, biology, and resource differences among individuals.²⁰ Necessary legal and bureaucratic requirements to gather data and report on mortality and morbidity measures coupled with the importance of providing programs and services to bring those rates down, constrains attention to broader analysis. Such analysis would include, for example, examining the connection between health outcomes unequal power relations.²¹

Second, health inequity is a slow-moving, cumulative type of catastrophe that people and their communities experience over long periods. It is often invisible to direct observation, even if persistent. Finally, building trust with community residents and incorporating their locally based information has been difficult in many jurisdictions.

The Relevance of Theoretical Frameworks for Public Health Practitioners

Making sense of data or information in public health always entails assumptions, premises, values, and interests because scientific knowledge is embedded within its social, cultural, and historical context. As social epidemiologist Nancy Krieger notes,

data of any type—including public health data—are not and never have been simply a “given.” No data bases have ever magically arrived, ready-made, complete with predefined categories and chock full of numbers. Instead, their form and content reflect decisions made by individuals and institutions and, in the case of public health data, embody underlying beliefs and values about what it is we need to know...²²

Efforts to explain why things are as they are start with ideas, organized concepts, and categories of thinking. The inclination to ask particular questions involves predetermined ways of conceiving reality. Theoretical frameworks are the mental model or logical structure of linked ideas that help to clarify relevant concepts, relationships, and explain trends or events. A framework is essentially a linking of theories with concepts to support the interpretation of knowledge. Purposefully formulated, they assist analysts in either challenging or advancing knowledge. In public health, theoretical frameworks are useful for exploring possible causes of health inequities, comparing assumptions and concepts within different approaches used by public health practitioners to conduct their practice and make findings meaningful. They influence consideration of realistic, possible, or desirable paths in tackling important public health issues.²³

Theoretical frameworks affect:

- ◆ legitimate sources of knowledge (the sources we consider trustworthy);
- ◆ research questions pursued or ignored (e.g., do we study the poor or do we study which policies produce poverty?);
- ◆ the attribution of responsibility and accountability for health or illness;
- ◆ the definition of a problem to investigate;
- ◆ beliefs and values in developing and reporting data;
- ◆ how and where to use public resources;
- ◆ the perception of health inequities determined by social injustices versus random outcomes;
- ◆ the type of data chosen to collect and analyze.

Revising Frameworks

How might public health practitioners reframe their scope of practice, in relation to incorporating the behavior of institutions and power structures as legitimate and researchable areas of interest necessary to assuring the public's health? How does this connect to theory?

Nancy Krieger identifies two distinctive theoretical approaches from recent literature in public health. Quoted at length, they express, for our purposes, the importance of theoretical frameworks and their influence over the direction of research, including root causes. They also express the difference between an approach that is more likely to lead to familiar forms of mitigating the consequences of health inequity (the first one below) versus one that may lead to thinking about requirements for acting on the root causes. Citing extensive literature, she explores differences within these two approaches, comparing one derived from the WHO and a conception discussed by Anne-Emanuelle Birn, an analyst of the politics of international health.

1. View *social determinants of health* as arising from a “social environment,” structured by government policies and status hierarchies, with social inequalities in health resulting from diverse groups being differentially exposed to factors that influence health—hence social determinants act as the *causes of causes* (WHO CSDH).

versus

2. Posit *societal determinants of health* as political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions; *societal determinants* thus become *the causes of causes of causes*.²⁴

Implications of Choosing a Definition of Health and Identifying the Scope of the Knowledge Base

Given that the causes of health inequity are to be found in institutions and social relations external to public health, the scope or boundaries for practice would be broad. The WHO definition of health, for example (“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”) does not extend far enough to encompass a conception that accounts for why health is necessary. Amartya Sen suggests that health is an important aspect of achieving human capabilities to lead a flourishing existence. He emphasizes the necessity of “the capability to achieve good health.” That in turn requires attention to “...issues of justice in social arrangements, including economic allocations [and] the role of health in human life and freedom.”²⁵ Sen’s approach emphasizes more specifically that “considerations of health be integrated with broader issues of social justice and overall equity...”²⁶

In a similar vein, going further, public health historian Elizabeth Fee notes:

When the history of public health is seen as a history of how populations experience health and illness, how social, economic, and political systems structure the possibilities for healthy or unhealthy lives, how societies create the preconditions for the production and transmission of disease, and how people, both as individuals and as social groups, attempt to promote their own health or avoid illness, we find that public health history is not limited to the study of bureaucratic structures and institutions but pervades every aspect of social and cultural life. Hardly surprisingly, these questions direct attention to issues of power, ideology, social control, and popular resistance.²⁷

Asking Questions to Develop Theory

Questions asked in public health often derive from experience. Question choices and methods always link to theory, even if unstated. What might be some questions to ask, given the assumptions and framework example outlined above for health equity?²⁸

- ◆ How and why do particular neighborhoods bear a heavier burden of polluting industries, waste disposal sites, unsafe housing, and high unemployment that lead to disease and illness?²⁹
- ◆ In what ways do political-economic systems shape health inequities?³⁰
- ◆ What are the cumulative health effects of social and economic inequality and lower living standards?
- ◆ What explains the production, maintenance and persistence of health inequities in different communities?
- ◆ What arrangements of power and patterns of decision making exclude and marginalize populations, making it difficult to achieve acceptable levels of well-being?
- ◆ What conditions might reverse the inequalities that lead to health inequity?
- ◆ What kinds of information might be useful in answering these questions?

Theoretical frameworks help us consider what or who is responsible for inequitable population health outcomes. An example of how avoiding theory or information not based in science can lead to asking the wrong questions can be seen in the story of the Tohono O'odham Nation, also known as the Pima Indians in Southern Arizona, as documented in the PBS series *Unnatural Causes*.³¹ They had the highest rate of Type 2 diabetes in the world and the federal government spent more than \$200 million investigating their genes over decades. The actual cause was due to the dispossession of their land, water, and culture. In addition to the stress of poverty leading to difficulties in controlling blood sugar, they had changes to their food supply. The dispossession began in 1930 when the Pima's water rights were removed so the government could gain control of the waterways in order to build the Hoover Dam. Many died of starvation. The military shipped in food in warehouses over decades. Most of it was junk—white flour, cheese, refined sugar, lard, and canned foods. This led to diabetes. The point: researchers asked the wrong questions. They knew little about or ignored the history of a people, their living conditions, or their dispossession.

The position and interests of those engaged in research influences the knowledge base, because all knowledge production is a social enterprise. Those interests affect outcomes, given the strong connection between politics, values, and knowledge. This does not deny the realization of good science. However, the standpoint and purpose of those experiencing health inequities play a significant part requiring attention. Communities and their interests play a critical role in making decisions about the purpose and uses of knowledge.

Working with Communities: Devising a Process for Gathering and Interpreting Information and Its Application

The health of communities and their residents are the reasons LHDs conduct their work. As such, without the cooperation and full participation of the communities they serve, LHDs cannot produce useful knowledge on health inequity.

Building community relationships is a dynamic, ongoing interaction, based on trust and reciprocity, as a basis for shared decision making. It cannot be measured or implemented merely as an activity. These relationships, always changing, need constant renegotiation, whereby community residents are true partners. Full participation would occur in planning, implementing, and evaluating public health actions in an equitable process. It also means health departments support the community by participating in neighborhood actions.

Sharing control and power with community groups by supporting and respecting them in decisions about their neighborhoods involves showing humility, not only expertise. This involves working closely to identify risk, not merely communicating it. The LHD would not then unknowingly impose the cultural norms of bureaucracies, acting only as experts.

A community's capacity to participate in decision making depends on the LHD recognizing itself as part of the community and within the community. The LHD determines its work in conjunction with the residents, based on their concerns. They have a right to participate, receive evidence, and define issues, regardless of expertise, because their lives are most affected.

The knowledge possessed by community residents (often referred to as local or indigenous)³² is equally valid on many counts with knowledge the LHD has to offer.³² It may be a different kind of knowledge (historical, unpublished reports, narratives, images, systematic or documented observation) and less scientific (geographic, place-based, community characteristics, experiential, conditions inside the home), but vital nonetheless, particularly in translation to professionals with respect to its meaning.

Jason Corburn contends that such knowledge is organized and based on "a practice of knowledge-making by certain peoples that occurs through experiential learning rather than a fixed body of information waiting to be acquired...."³³ Offering community organizations technical assistance, for example, conducting their own health assessments, planning and evaluation, and guidelines for community development are ways to identify and use such information.³⁴ Knowledge situated in the language, experience, and culture of those who can benefit can be more fruitful.³⁵ Communities add value in identifying questions that guide public health practice. Residents also can provide information and local accounts of their neighborhoods that offer insights, adding to scientific knowledge and non-scientific but legitimate knowledge to explain realities of inequality.

Community participation in developing and offering knowledge is a means to democratize it by challenging not only data but method, interpretation, and use. Public health knowledge is meant to justify decisions, not for its own sake. It can be used to generate more effective public health strategies to tackle health inequities, integrating research, knowledge, and action. The links with organized community efforts to promote social and economic justice, human rights, and sustainable practices can promote the health of future generations. A powerful example of knowledge co-creation directed at institutional causes is the collaboration between the Alameda County Health Department and Justa Causa/Just Cause in Oakland, California, to examine the effect of home foreclosure on health³⁶ (see below).

Public health officials will be able to anticipate health issues by receiving genuine feedback. By building trust they will have strong allies in support of its work, and be better able to take more risks in protecting public health with that support—for example, in playing a larger role in areas such as economic redevelopment. Working effectively with the community often means a transformation in the way LHDs conceptualize their work, from its organizational structure and programs to staff attitudes.

Health officials can further strengthen their capacity to promote public health through alliances with social movements. The potential for organized efforts by the civil rights, environmental justice, organized labor, and feminist and gender movements to affect public health presents an opportunity for LHDs, especially during a period of rising economic inequalities. Few non-governmental organizations with missions that coincide with the public health goal of assuring the conditions that promote health have the capacity to conduct or use research that can identify threats to public health and prompt strategies to address them. By partnering with non-governmental organizations that promote a social justice perspective, LHDs can use their epidemiologic capacity to educate the public about health inequities and their causes.³⁷

Potential Application: Community Health Assessments

Traditionally, a community health assessment is a systematic process that uses quantitative and qualitative methods to collect and analyze data to understand the causes of health outcomes. The assessment goal is generally to develop strategies to meet the community's health needs. Assessments can include information on quality of life, mortality, morbidity, community assets, social determinants of health and health inequity, and the performance of the public health system. Community health assessment data can inform community decision making, prioritize health problems, and develop and implement community health improvement plans.

The Affordable Care Act requires non-profit hospitals to conduct a community health assessment and improvement plan with public health and the community. Will this process be deployed to focus specifically on issues of health equity? If so, community residents would be co-determining planners of the process. In choosing what to assess, they might consider some of the following: decline in levels of literacy, labor market changes such as the economic division of labor, and flows of capital in and out of communities, and labor market events like unemployment, changes in the labor supply, and changes in earnings. They might also explore the links with growing economic insecurity that create health risks.

The Alameda Foreclosure Study

Rebuilding Neighborhoods, Restoring Health, a joint effort between the Alameda County Health Department and Justa Causa/Just Cause (JCCJ), a housing justice organization, describes the extensive health and economic effects of home foreclosures on individual residents and neighborhoods in Oakland, California. It ties the current crisis to a legacy of housing discrimination, and provides recommendations to alleviate and prevent further health crises resulting from foreclosure.³⁸ The study suggests ways in which public health can align itself effectively with communities' needs. In this case, the LHD had a prior relationship with JCCJ, on previous campaigns to explore health effects, where trust was built. JCCJ contacted the LHD to work with them and much preparation led to their successes. They spent months sharing their world view of making change, recognizing differences in language and culture, and identifying similarities. The LHD wanted to work with JCCJ as they engaged in base building. As the study design was developed, the JCCJ Board reviewed it and sent it to their membership. The final research strategy was a joint effort. The LHD learned that it was not enough to write a report; the power to generate action was critical and the department used its institutionalized power to take action. They saw themselves as an objective agency acting in the public interest. Their job was to exercise their power for the public, to advance community health. In addition, JCCJ gained access to institutions and places from which they were formerly excluded.³⁹

LHDs need not see communities as recipients of methods developed by research specialists. By virtue of their responsibility for improving public health, they can become leaders in developing a local knowledge base engaged with the physical, biological, social, and economic systems that limit the prospects for the world's wealthiest country to achieve a respectable level of public health for all.

Conclusion

Someone once said that practice without theory is blind and theory without practice is empty.

With respect to the former, a coherent theoretical framework can serve as an effective guide to action in setting priorities and identifying relevant questions, which can lead to explanations of causes at the level of structures and systems.⁴⁰ The purpose of knowledge for health equity is to connect it to public health practice and from there to collective action for social change, knowledge alone is insufficient to affect change. Strategies devised with social movements are necessary, as is full cooperation with affected populations. As epidemiologist Steven Wing contends, working with communities will “enrich the hypotheses, methods, substantive content, and policy implications of research” for health equity.⁴¹ More than that, it demonstrates a potential model for a democratic process that is itself a goal toward achieving health equity.

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